DIE OPERATIONEN BEI MITTELOHREITERUNGEN UND IHREN INTRAKRANIELLEN KOMPLIKATIONEN. Für Aerzte und Studierende von DR. B. HEINE. 8vo, pp. 197. S. Karger, Berlin, 1906.

This is altogether a very satisfactory work, which will well repay the aurist to read in the original. To some of its teachings brief reference will be made. Thus: in middle ear inflammation, paracentesis is indicated if bulging exists, accompanied by fever and severe pain. Inflation is contraindicated in acutely inflamed ears. Paracentesis is also indicated when mastoid tenderness or swelling of the soft parts already exists. This applies more forcibly when symptoms of meningeal irritation appear.

Chapter 3 is devoted to the discussion of "Removal of the Ossicles." He is sceptical as to the benefits of this operation, as when the ossicles only are affected, expectant treatment may bring about a cure, and if other structures are involved the radical operation must finally be done. Consequently he only recommends ossiculectomy when the ossicles are affected and the hearing is considerably reduced and expectant treatment has been without avail.

In Section II, Chapter 2 and 3, "Opening of the Mastoid Process and of the Antrum" is discussed. Local anesthesia can be employed, if general anæsthesia bids fair to prove dangerous. All loose bone attached to the dura must be removed with blunt hooks, as, if left, it may bring about gangrene of the dural wall. Diseased dura should be widely exposed up to its healthy limits. If it be necessary to remove the whole posterior osseous canal wall, he endorses Winkler's recommendation to form a flap of the posterior soft canal wall and tamponade it into the mastoid wound, so as to bring about a patulent canal.

Every collection of granulations must be removed and followed to its termination in healthy bone. He uses the electric head-lamp for illumination. Iodoform gauze, loosely packed, is used.

A trial of Bier's treatment for acute mastoiditis in Heine's clinic on 15 cases, gave 9 cases coming to operation. If the local and general symptoms do not soon improve, then one must not delay operation (and, in the experience of the reviewer, even such

improvement under this plan of treatment may only serve to hide serious mastoid and intracranial involvement in recurrent cases of acute mastoiditis). As a rule, the radical operation is indicated in every case of cholesteatomatous middle ear suppuration. Heine believes in the trial of conservative measures first. He recommends for irrigation a weak formaline solution. The operation is indicated when no improvement appears, when the discharge continues fœtid; when in chronic suppuration an acute mastoiditis develops or symptoms of intracranial involvement appear.

Heine states that the point of predilection for involvement of the labyrinth is the horizontal semicircular canal, especially on its convexity or its anterior angle. When we have vertigo, the best proof that it truly depends upon a disturbance of equilibrium is given when we can demonstrate nystagmus; and then the operation must not be delayed. The same warning obtains should facial paralysis appear.

In 22 out of 63 cases of uncomplicated diffuse purulent meningitis occurring in the Berlin University ear clinic, the cause of this fatal disease was a suppuration of the labyrinth. Operation on the labyrinth always entails a certain danger to the patient. We can not with certainty differentiate between a circumscribed and a diffuse labyrinthitis. The irritative symptoms are, for the cochlea, subjunctive tinnitus; for the vestibular apparatus, vertigo, disturbances of equilibrium, nystagmus, nausea and vomiting. The destructive symptoms are, for the cochlea, deafness; and for the vestibule and semicircular canals, disturbances of equilibrium without vertigo and nystagmus. Barany's test; if one syringes a normal or suppurating ear, whose vestibular apparatus is intact, with water below the body temperature, there occurs a rotary nystagmus toward the opposite side and the reverse, toward the syringed ear, occurs if the temperature of the water is above that of the body. If no nystagmus appears, then the vestibular apparatus of the diseased ear is destroyed.

Heine concludes: If a defect of the semicircular canal is found, at first leave it alone, but if labyrinthine symptoms then do not disappear or augment, or first appear after operation with augmentation of the general symptoms, indicating meningitis, then operate on the labyrinth.

In Phlebitis and Thrombosis of the Transverse Sinus and the Jugular Vein, Griesinger's symptom, tender circumscribed œdema on the posterior border of the mastoid process, is uncertain, as it may be caused by disease of the bone or frequently by extradural abscesses in the posterior cranial fossa; Gerhardt's symptom, unequal fullness of the external jugular, is also unreliable, and Heine joins with Körner in stating that he has never observed it. The diagnosis is practically impossible if there are no decided symptoms of a general pyæmic infection. Perisinous abscesses, as a rule, give no symptoms on which to base a diagnosis before operation. With high fever, especially in children, every other cause for the fever must be excluded. Exposure of the sinus is not to be considered as a harmless procedure. When in doubt, Heine punctures the sinus as an exploratory measure, and believes this to be much less dangerous than incision, principally because it is not necessary to pack after puncture. He removes the thrombus only so far as it is broken down, and depends upon Nature and frequent changing of dressings to take care of the infection; in exceptional cases, the thrombus is completely removed, especially in the streptococcic infections. Ligation of the jugular is reserved for certain cases only, in which it is clearly indicated.

The question of ligation of the jugular in sinus thrombosis is still debatable; in fact, it may favor an extension of the process to other sinuses, the inferior petrosal, the cavernous, etc.; there is the danger that the internal jugular vein of the sound side may be rudimentary, when cerebral œdema or necrosis may follow. (Linser found that in 3 per cent. one jugular foramen was only from three to four mm. in size.) Heine ligates when the thrombus is broken down and the sinus wall is discolored; in other cases, if the temperature remains high after operation or mounts after a preliminary fall, with rigors, then the bulb must be cleaned out and the jugular vein be widely opened.

For operative evacuation of Brain Abscesses, he recommends attack through the mastoid, also trial punctures with large canulæ rather than incisions. Heine would not fear to introduce the canula up to 7 cm. If an abscess is discovered, then the dura is incised in the direction of the length of the temporal convolutions. He uses a drainage tube wrapped around with iodoform gauze. One should always remember that brain abscesses are relatively rare, but general brain symptoms, that appear to indi-

cate abscess formations, can appear quite frequently in the course of middle ear suppurations.

In Meningitis Serosa, a certain diagnosis is not yet possible; lumbar puncture is to a certain degree helpful. Removal of the focus of disease in the middle ear and exposure of the diseased portion of the brain usually suffices.

In Meningitis Purulenta, the prognosis, as with the serous form, is no longer absolutely bad; the middle ear is to be operated upon as early as possible. Circumscribed purulent meningitis is curable. As a rule, to which there are no exceptions, we will not go wrong, if we find by lumbar puncture a purulent liquor containing bacteria, to conclude that we have to do with a lepto-meningitis purulenta. Heine holds diffuse purulent meningitis to be incurable. From a clinical point of view, it is not possible to differentiate the circumscribed from the diffuse form.

Operation consists in eliminating the infective focus in the bone and exposing the dura, so far as it appears to be unhealthy; in the serious form, we can incise the dura; and finally, we can use lumbar puncture to withdraw a portion of the purulent fluid.

Lumbar Puncture: In otitis with intracranial complications this is not certainly free from danger; *e.g.*, the withdrawal of the liquid may lead to the rupture of an abscess into the ventricle. If from the clinical picture we believe the diagnosis of purulent meningitis justifiable, then we do a lumbar puncture; if the liquid is distinctly purulent and contains bacteria, we do not operate, even if it contains bacteria, or is a purulent liquor without bacteria.

HENRY A. ALDERTON.

NIERENCHIRURGIE. Ein Handbuch für Praktiker von PROF. DR. C. GARRÉ, Geh. Med.-Rath. Direktor der Chirurg. Klinik der Universitat Breslau; und DR. O. EHRHARDT, Privatdocent für Chirurgie an der Universitat Konigsberg i. Pr. Mit 90 Abbildungen im Text. Berlin, 1907. Verlag von S. Karger, Karlstrasse 15.

Together with Küster's contribution on Renal Surgery in "Deutsche Chirurgie, and Israel's Monograph of Surgical Kidney Diseases, the "Nierenchirurgie" of Garré & Erhardt, under consideration constitutes a triad of the German conception of surgical affections of the kidney. Very different from its forerunners, we note in this latest book a very liberal acknowledg-